		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028480

Facility Name: MOMENCE MEADOWS NURSING CENTER

Address: 500 SOUTH WALNUT (Number) MOMENCE (City) 60954 (Zip Code)

County: KANKAKEE

Telephone Number: (815) 472-2423 **Fax #** (815) 472-6212

IDPA ID Number: 36-3269481

Date of Initial License for Current Owners: 02/01/84

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JACOB GRAFF

(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	140	Skilled (SNF)	140	51,240	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	41,213	3,521	2,974	47,708	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,213	3,521	2,974	47,708	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.11%

D. How many bed-hold days during this year were paid by Public Aid?
777 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 2827

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTE # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	195,975	15,539	9,553	221,067		221,067	0	221,067			1
2	Food Purchase		211,607		211,607	(11,701)	199,906	(162)	199,744			2
3	Housekeeping	160,788	16,566	0	177,354		177,354	0	177,354			3
4	Laundry	86,725	33,558	0	120,283		120,283	0	120,283			4
5	Heat and Other Utilities			105,553	105,553		105,553	248	105,801			5
6	Maintenance	0	22,462	55,448	77,910		77,910	(1,093)	76,817			6
7	Other (specify):*			10,123	10,123		10,123	0	10,123			7
8	TOTAL General Services	443,488	299,732	180,677	923,897	(11,701)	912,196	(1,007)	911,189			8
	B. Health Care and Programs											
9	Medical Director			10,737	10,737		10,737	0	10,737			9
10	Nursing and Medical Records	1,404,030	44,791	19,423	1,468,244		1,468,244	0	1,468,244			10
10a	Therapy	106,693		4,458	111,151		111,151	0	111,151			10a
11	Activities	80,988	14,751	659	96,398		96,398	0	96,398			11
12	Social Services	54,530		4,117	58,647		58,647	0	58,647			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,646,241	59,542	39,394	1,745,177		1,745,177		1,745,177			16
	C. General Administration											
17	Administrative	98,818		761,451	860,269		860,269	(726,963)	133,306			17
18	Directors Fees			0				0				18
19	Professional Services			249,565	249,565		249,565	(141,064)	108,501			19
20	Dues, Fees, Subscriptions & Promotions			54,429	54,429		54,429	(29,382)	25,047			20
21	Clerical & General Office Expenses	37,169	17,004	356,617	410,790		410,790	(200,477)	210,313			21
22	Employee Benefits & Payroll Taxes			309,128	309,128	11,701	320,829	0	320,829			22
23	Inservice Training & Education			5,421	5,421		5,421	50	5,471			23
24	Travel and Seminar			0				0				24
25	Other Admin. Staff Transportation			34,559	34,559		34,559	0	34,559			25
26	Insurance-Prop.Liab.Malpractice			57,791	57,791		57,791	0	57,791			26
27	Other (specify):*			0				20,374	20,374			27
28	TOTAL General Administration	135,987	17,004	1,828,961	1,981,952	11,701	1,993,653	(1,077,462)	916,191			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,225,716	376,278	2,049,032	4,651,026		4,651,026	(1,078,469)	3,572,557			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTE # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			122,564	122,564		122,564	37,355	159,919			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			764,672	764,672		764,672	(37,807)	726,865			32
33	Real Estate Taxes			54,310	54,310		54,310	0	54,310			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			54,802	54,802		54,802	7,533	62,335			35
36	Other (specify):* MTG AMORT			62,487	62,487		62,487	0	62,487			36
37	TOTAL Ownership			1,058,835	1,058,835		1,058,835	7,081	1,065,916			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		109,669	109,899	219,568		219,568	0	219,568			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			76,860	76,860		76,860	0	76,860			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		109,669	186,759	296,428		296,428		296,428			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,225,716	485,947	3,294,626	6,006,289	0	6,006,289	(1,071,388)	4,934,901			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	37,355	30		9
10	Interest and Other Investment Income	(37,807)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(162)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(425)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(142,000)	19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(25,210)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(4,276)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(1,093)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (173,618)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(897,770)	SCHED	34
35	Other- Attach Schedule	0	ITACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (897,770)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (1,071,388)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS **Page 5A**

Facility Name **MOMENCE MEADOWS NURSING CENTER**

ID# **0028480**

Report Period Beginning: **01/01/2000**

Ending: **12/31/2000**

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(162)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	(1,093)
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	(1,255)
9	**Non-Straightline Depreciation**	37,355	30	**Line 9**	0
10	**Interest and Other Investment Income**	(37,807)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(162)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	0	20	**Line 16**	0
18	**Fines and Penalties**	0	21	**Line 17**	0
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	(425)	20	**Line 19**	(142,000)
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(29,911)
22	**Special Legal Fees & Legal Retainers**	(142,000)	19	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	0	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(25,210)	20	**Line 24**	0
26	**Income & IL Personal Property ReplacementTaxes**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	(4,276)	20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(171,911)
30	**Donated Goods**	0	0	**Line 29**	(173,166)
31	**Amortization Expense**	0	0	**Line 30**	37,355
32	DEFERRED MAINTENANCE COSTS SCH XIX-H	(1,093)	6	**Line 31**	0
33				**Line 32**	(37,807)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(452)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(173,618)
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1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(162)	0	0	0	0	0	0	0	0	0	0	(162)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	248	0	0	0	0	0	0	0	0	0	248	5
6	Maintenance	(1,093)	0	0	0	0	0	0	0	0	0	0	(1,093)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,255)	248	0	0	0	0	0	0	0	0	0	(1,007)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(726,963)	0	0	0	0	0	0	0	0	0	(726,963)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(142,000)	936	0	0	0	0	0	0	0	0	0	(141,064)	19
20	Fees, Subscriptions & Promotions	(29,911)	529	0	0	0	0	0	0	0	0	0	(29,382)	20
21	Clerical & General Office Expenses	0	(200,477)	0	0	0	0	0	0	0	0	0	(200,477)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	50	0	0	0	0	0	0	0	0	0	50	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	20,374	0	0	0	0	0	0	0	0	0	20,374	27
28	**TOTAL General Administration**	(171,911)	(905,551)	0	0	0	0	0	0	0	0	0	(1,077,462)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(173,166)	(905,303)	0	0	0	0	0	0	0	0	0	(1,078,469)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	37,355	0	0	0	0	0	0	0	0	0	0	37,355	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(37,807)	0	0	0	0	0	0	0	0	0	0	(37,807)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	7,533	0	0	0	0	0	0	0	0	0	7,533	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(452)	7,533	0	0	0	0	0	0	0	0	0	7,081	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(173,618)	(897,770)	0	0	0	0	0	0	0	0	0	(1,071,388)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Page 6

Facility Name & ID Number: MOMENCE MEADOWS NURSING CENTE — # 0020480 — Report Period Beginning: 01/01/2008 — Ending: 12/31/2008

VII. RELATED PARTIES — [Show Pgs 6A thru 6D] [Show Pgs 6E thru 6I] [Hide Pgs 6A thru 6I]

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ATTACHED SCHEDULE		SKOKIE MEADOWS 1	SKOKIE	PREMIER MGMNT	SKOKIE	MANAGEMENT
		SKOKIE MEADOWS 2	SKOKIE			BOOKKEEPING
		SHELDON MEADOWS	SHELDON			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 6)		Sum_6
1	V	22 MANAGEMENT FEE	761,451	-		$	$ (761,451)	1	-761451
2	V	23 OCTOBER CLERICAL	211,000	-			(211,000)	2	-211000
3	V	5		PREMIER MANAGEMENT	100.00%	248	248	3	248
4	V	15		PREMIER MANAGEMENT	100.00%	34,488	34,488	4	34488
5	V	19		PREMIER MANAGEMENT	100.00%	936	936	5	936
6	V	20		PREMIER MANAGEMENT	100.00%	529	529	6	529
7	V	21		PREMIER MANAGEMENT	100.00%	56,463	56,463	7	56463
8	V	27		PREMIER MANAGEMENT	100.00%	20,374	20,374	8	20374
9	V	32		PREMIER MANAGEMENT	100.00%	50	50	9	50
10	V	35		PREMIER MANAGEMENT	100.00%	7,533	7,533	10	7533
11	V	37		PREMIER MANAGEMENT	100.00%	54,060	54,060	11	54060
12	V							12	
13	V							13	
14	Total		1,472,451			$ 174,681	$ * (807,770)	14	

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6A

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENT # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACOB GRAFF	PRESIDENT	Administrative	14.30	63,751	7	14.00	Mnmnt fee	$ 34,488	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 34,488		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREMIER MANAGEMENT
Street Address: 9933 N. LAWLER
City / State / Zip Code: SKOKIE,IL,60077
Phone Number: (847)679-7733
Fax Number: (847)679-7734

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	10,000	5	$ 900	$ 0	2,759	$ 248	1
2	17	OFFICER SALARY	PER RESIDENT DAY	10,000	5	125,000	125,000	2,759	34,488	2
3	19	DATA PROCESSING	PER RESIDENT DAY	10,000	5	3,394	0	2,759	936	3
4	20	DUES & SUBSCRIPTIONS	PER RESIDENT DAY	10,000	5	1,919	0	2,759	529	4
5	21	CLERICAL	PER RESIDENT DAY	10,000	5	204,649	134,850	2,759	56,463	5
6	27	PAYROLL TAXES	PER RESIDENT DAY	10,000	5	73,847	0	2,759	20,374	6
7	23	SEMINARS	PER RESIDENT DAY	10,000	5	183	0	2,759	50	7
8	35	OFFICE RENT	PER RESIDENT DAY	10,000	5	27,304	0	2,759	7,533	8
9	21	CLERICAL	PER RESIDENT DAY	10,000	5	153,972	153,972	3,511	54,060	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 591,168	$ 413,822		$ 174,681	25

Print Preview

Print Page 8A

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTI # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LTC PROPERTIES		X	MORTGAGE	$42,919.00	01/22/93	$ 4,100,000	$			$	1
2											174,013	2
3											504,664	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BK		X	WORKING CAPITAL	INTEREST						10,336	6
7	SUCCESS NATIONAL BANK		X	WORKING CAPITAL	$5,595.00		180,000	69,038		PRIME+	25,169	7
8	COLE TAYLOR		X	WORKING CAPITAL	INTEREST		586,159	586,159		PRIME+	50,490	8
9	TOTAL Facility Related				$48,514.00		$ 4,866,159	$ 655,197			$ 764,672	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,866,159	$ 655,197			$ 764,672	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$ 55,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 55,005	2
3. Under or (over) accrual (line 2 minus line 1).	$ (695)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 55,005	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 54,310	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	53,802	8
1996	58,941	9
1997	58,840	10
1998	55,642	11
1999	55,005	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,850 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	0		$ 26,183	1
2				6,000	2
3	TOTALS	0		$ 32,183	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	78		1983		$ 1,071,430	$ 0	20	$ 53,572	$ 53,572	$ 912,955	4
5			1983		28,288	0	19	1,489	1,489	25,073	5
6	50		1989		1,359,883	43,171	31.5	43,171		483,858	6
7	12		1994		381,788	9,789	39	9,789		66,496	7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	IMPROVEMENTS			1984	11,728	0	15	782	782	10,846	9
10	IMPROVEMENTS			1985	10,412	548	10	521	(27)	8,075	10
11	IMPROVEMENTS			1986	8,150	429	20	408	(21)	5,916	11
12	IMPROVEMENTS			1987	1,655	52	20	83	31	1,121	12
13	IMPROVEMENTS			1987	513	16	20	26	10	351	13
14	IMPROVEMENTS			1988	33,260	1,056	31.5	1,056		13,244	14
15	IMPROVEMENTS			1989	9,914	315	31.5	315		3,498	15
16	IMPROVEMENTS			1990	7,043	223	31.5	223		2,290	16
17	IMPROVEMENTS			1991	66,745	2,118	31.5	2,118		20,164	17
18	IMPROVEMENTS			1992	14,756	468	31.5	468		4,025	18
19	IMPROVEMENTS			1993	3,240	103	31.5	103		811	19
20	IMPROVEMENTS			1993	18,662	479	39	479		3,373	20
21	IMPROVEMENTS			1994	2,799	72	39	72		477	21
22	BOOSTER PUMP & MIXING VALVE			1995	7,865	201	39	201		1,101	22
23	TWO WATER HEATERS			1995	6,886	176	39	176		1,024	23
24	HALLWAY HEATER			1995	815	21	39	21		106	24
25	STEEL DOOR			1996	1,679	43	39	43		206	25
26	PLUMBING			1996	3,219	82	39	82		369	26
27	TILE,WALL BUMPERS,HAND RAIL & RIGIWALL			1996	26,342	675	39	675		2,728	27
28	CORNERGUARDS, WALL BUMPER & HANDRAIL			1997	1,584	40	39	40		158	28
29	REWIRE NURSE STATION ROOFTOP UNIT			1997	4,298	110	39	110		427	29
30	ALZHEIMERS REMODELING			1997	11,002	282	39	282		1,093	30
31	ROOF TOP UNITS			1997	7,875	202	39	202		783	31
32	CONCRETE WORK			1997	1,650	42	39	42		152	32
33	HVAC			1997	3,912	100	39	100		338	33
34	EMERGENCY LIGHTING			1997	4,125	106	39	106		358	34
35	ROOF TOP HEATING/AC UNIT			1997	6,500	166	39	166		573	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 61,085		$ 116,921	$ 55,836	$ 1,571,989	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	ROOF TOP UNIT, CORNER GUARDS, CORRIDER CALL LIFES			1998	12,400	318	39	318		913	9
10	NEW DRIVEWAY, FIRE DRAWER, BACKFLOW PREVENTOR			1998	16,667	427	39	427		1,120	10
11	ROOF TOP UNITS			1998	13,126	336	39	336		799	11
12	ROOF INSULATION, RUBBER COVE BOX, ROOF TOP UNIT			1998	23,942	614	39	614		1,305	12
13	ROOF TOP A/C UNIT			1999	6,673	171	39	171		264	13
14	DOORS			1999	2,892	74	39	74		114	14
15	COUNTERTOPS WITH SINKS & FAUCETS			1999	3,460	88	39	88		136	15
16	LIFT STATION FOR DRAIN PLUMBING			1999	2,971	76	39	76		117	16
17	DOORS			1999	1,635	42	39	42		65	17
18	FIRE ALARM PANEL			1999	1,585	40	39	40		62	18
19	EXHAUST FAN			1999	870	22	39	22		34	19
20	ALARM			1999	2,123	54	39	54		83	20
21	EXHAUST FAN			1999	900	23	39	23		36	21
22	COMPRESSOR			1999	2,942	75	39	75		116	22
23	PANNING CAMERA			1999	1,940	49	39	49		76	23
24	BOOSTER FOR WATER HEATER			1999	3,114	80	39	80		123	24
25	CUSTOM NURSING DESK			2000	6,567	119	27.5	119		119	25
26	WATER SOFTENER			2000	5,850	106	27.5	106		106	26
27	TREES			2000	10,974	366	15	366		366	27
28	BASEBOARD HEATERS			2000	4,773	87	27.5	87		87	28
29	CARPETING			2000	10,858	1,552	10	543	(1,009)	543	29
30	BORDER INSTALLATION & PAINTING			2000	23,938	3,421	10	1,197	(2,224)	1,197	30
31											31
32	**IMPROVEMENTS				18,872		20	944	944	15,576	32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 8,140		$ 5,851	$ (2,289)	$ 23,357	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
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29											29
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 357,730	$ 44,691	$ 35,070	$ (9,621)	10 YRS	$ 169,384	37
38	Current Year Purchases	60,417	8,648	3,021	(5,627)	10 YRS	3,021	38
39	Fully Depreciated Assets	547,879					547,879	39
40								40
41	TOTALS	$ 966,026	$ 53,339	$ 38,091	$ (15,248)		$ 720,284	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	HSKG,DIET,MAINT,NSG	93 FORD SUP	94	$ 39,109	$ 0	$ 0	$	4	$ 39,109	42
43										43
44										44
45										45
46	TOTALS			$ 39,109	$	$	$		$ 39,109	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 122,564	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 160,863	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 38,299	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,354,739	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 25,892 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	SEE ATTACHED SCHEDULE		$	$ 28,910	17
18					18
19					19
20					20
21	TOTAL		$	$ 28,910	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			79,669			79,669	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				92,781		92,781	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	laboratory, rentals, IV therapy, & Med B Other (specify): MEDICAL SUPPLIES					30,230	16,888		30,230 16,888	13
14	TOTAL			$		$ 109,899	$ 109,669		$ 219,568	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 815,060	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	724,235		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,277		6
7	Other Prepaid Expenses	7,983		7
8	Accounts Receivable (owners or related parties)	965,041		8
9	Other(specify):	33,477		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,591,073	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,183		13
14	Buildings, at Historical Cost	1,099,718		14
15	Leasehold Improvements, at Historical Cost	2,178,500		15
16	Equipment, at Historical Cost	1,005,135		16
17	Accumulated Depreciation (book methods)	(2,595,154)		17
18	Deferred Charges	115,321		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,835,703	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,426,776	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 165,449	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	863,046		29
30	Accrued Salaries Payable	50,858		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,005		32
33	Accrued Interest Payable	34,530		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,168,888	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,115,493		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,115,493	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,284,381	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,857,605)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,426,776	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (840,657)	1
2	Restatements (describe):		2
3	1999 POST CLOSING ENTRIES	(488,368)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,329,025)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(528,580)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (528,580)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,857,605)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,379,507	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,379,507	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	60,395	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 60,395	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	37,807	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 37,807	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,477,709	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 923,897	31
32	Health Care	1,745,177	32
33	General Administration	1,981,952	33
	B. Capital Expense		
34	Ownership	1,058,835	34
	C. Ancillary Expense		
35	Special Cost Centers	219,568	35
36	Provider Participation Fee	76,860	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,006,289	40
41	**Income before Income Taxes (line 30 minus line 40)****	(528,580)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (528,580)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 55,377	$ 26.62	1
2	Assistant Director of Nursing	2,000	2,080	41,536	19.97	2
3	Registered Nurses	6,578	6,892	114,788	16.66	3
4	Licensed Practical Nurses	23,709	25,290	391,324	15.47	4
5	Nurse Aides & Orderlies	77,521	80,609	749,300	9.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,681	7,296	106,693	14.62	8
9	Activity Director					9
10	Activity Assistants	7,492	7,857	80,988	10.31	10
11	Social Service Workers	4,068	4,251	54,530	12.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,915	25,228	195,975	7.77	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	12,909	13,494	160,788	11.92	18
19	Laundry	11,822	12,556	86,725	6.91	19
20	Administrator	2,000	2,080	58,624	28.18	20
21	Assistant Administrator	2,000	2,080	40,194	19.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,080	2,080	37,169	17.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,420	2,553	51,705	20.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,195	196,426	$ 2,225,716 *	$ 11.33	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,800	1-3	35
36	Medical Director	O	10,737	9-3	36
37	Medical Records Consultant	N	4,682	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,100	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	659	11-3	44
45	Social Service Consultant	E	4,117	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL CONSULTANS		0	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 29,095		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KERI HORN	ADMIN	0.00%	$ 58,624
PAULA DEDDO	ASST. ADMIN.	0.00%	40,194
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,818

B. Administrative - Other

Description	Amount
MANAGEMENT FEE	$ 761,451
TOTAL (agree to Schedule V, line 17, col. 3)	$ 761,451
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED		$ 249,565
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 249,565

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,074
Unemployment Compensation Insurance	20,355
FICA Taxes	169,279
Employee Health Insurance	78,483
Employee Meals	11,701
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	0
EMPLOYEE BENEFITS-OTHER	7,937
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 320,829

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,236
Health Care Worker Background Check	0
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	29,486
DUES & SUBSCRIPTIONS	7,798
LICENSES & PERMITS	484
TRUST FEES, CONTRIBUTIONS,etc.	425
MGMT CO ALLOCATION	529
LESS TRUST FEES, CONTRIB, etc.	(425)
Less: Public Relations Expense	( )
Non-allowable advertising	(25,210)
Yellow page advertising	(4,276)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,047

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	0
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATINC	7/97	$ 13,989	3 YRS	$ 2,332	$ 4,663	$ 4,663	$ 2,331	$	$	$	$	$
2	PAINT/DECORATINC	6/98	9,306	3 YRS		1,551	3,102	3,102	1,551				
3	PAINT/DECORATINC	6/00	7,831	3 YRS				1,305	2,610	2,610	1,306		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 31,126		$ 2,332	$ 6,214	$ 7,765	$ 6,738	$ 4,161	$ 2,610	$ 1,306	$	$

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Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE $5398

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 76,860
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 11,701 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER #0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	7800	
	REPAIRS & MAINTENANCE		1753	
			0	9553
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	HEAT & OTHER UTILITIES			
	GAS HEAT		32045	
	ELECTRICITY		52611	
	WATER		17264	
	CABLE TV - LOBBY		3633	
			0	105553
6	MAINTENANCE			
	GROUNDS MAINTENANCE		6302	
	PAINTING & DECORATING		7831	
	BUILDING REPAIRS		4917	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		23780	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1870	
	FIRE SERVICE		4835	
	CONTRACTED BUILDING MAINTENANCE		5913	
			0	
			0	55448
7	OTHER			
	SCAVENGER		10123	
	SECURITY SERVICE		0	10123
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	10737	10737
10	NURSING			
	CONTRACT NURSING	XVIII C53	0	
	LABORATORY & XRAY EXPENSE		2956	
	PURCHASED SERVICES		8370	
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	4682	
	PHARMACY CONSULTANT	XVIII B39	1100	
	UTILIZATION REVIEW FEES	XVIII B	0	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	0	
	DENTAL		2315	
			0	19423
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	4458	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	0	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B41	0	
	SPEECH THERAPY CONSULTANT	XVIII B43	0	
	RESPIRATORY CONSULTANT	XVIII B42	0	4458
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	659	
			0	659
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B45	212	
	SOCIAL WORKER	XVIII B45	3905	
			0	4117
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER #0028480 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		0	0
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	761451	761451
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	14312	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	235253	
	ACCOUNT COLLECTION FEES		0	249565
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT	VI 19 XIX F	0	
	ADV & PROMO/MARKETING	VI 25 XIX F	25210	
	EMPLOYEE WANT ADS	XIX F	16236	
	CONTRIBUTIONS	VI 20 XIX F	425	
	DUES & SUBSCRIPTIONS	XIX F	7798	
	LICENSES & PERMITS	XIX F	484	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	4276	
	TRUST FEES/FRANCHISE TAX	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	H/CARE WORKER BACKGROUND CHECK	XIX F	0	54429
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES		15233	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		311000	
	PENALTIES	VI 18	5733	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20771	
	MESSENGER SERVICE		1306	
	PERSONNEL COSTS		2574	356617
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES	XIX D	169279	
	UNEMPLOYMENT COMPENSATION	XIX D	20355	
	WORKERS COMPENSATION INSURANCE	XIX D	33074	
	HOSPITALIZATION INSURANCE	XIX D	78483	
	EMPLOYEE BENEFITS - OTHER	XIX D	7937	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING CONTRIB	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	309128
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		5421	5421
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	0
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		34559	34559
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		57791	57791
27	OTHER			
	BAD DEBTS	VI 24	0	
			0	0
	GRAND TOTAL COLUMN 3 OTHER			2049032

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER #0028480
EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 COLUMN 3 OTHER LINES 2 AND 22

TOTAL FOOD PURCHASE	211445	PATIENT MEALS	143124
LESS SALES TAX	162	ADD EMPLOYEE MEALS	8418
NET FOOD	211283	TOTAL MEALS/YEAR	151542
TOTAL PATIENT CENSUS	47708	NET FOOD	211283
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	151542
TOTAL PATIENT MEALS	143124	COST PER MEAL	1.39
		TIME EMPLOYEE MEALS	8418
ADD # EMPLOYEE MEALS/DAY	23		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	11701
TOTAL EMPLOYEE MEALS	8418		

76860	1058835		2225716
	0		
			0
(37,807)			
0			
	0		
0			
-6953			
174013	-174013		
-76860			
129253	884822	1014075	2225716
129253	1591471	-1014075	2225716
		-528580	